STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G313	A. BUILDING 00 B. WING	12/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	19038 MISSISSIPPI ST HEBRON, IN 46341

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0000	W0000 This visit was for the investigation of Complaint #IN00119881. Complaint #IN00119881: SUBSTANTIATED, Federal and state deficiencies related to the allegations are cited at W102, W104, W122, W149, W157, W240, W318, W331, W342 and W346. Unrelated deficiency cited. Dates of Survey: December 5, 6, 7, 10 and 14, 2012. Facility number: 000832 Provider number: 15G313 AIM number: 100249150 Surveyors: Christine Colon, Medical Surveyor III/QMRP-Team Leader Paula Chika, Medical Surveyor III/QMRP These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/20/12 by Ruth Shackelford, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W0102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Governing Body for 2 of 3 sampled clients (A and B). The governing body failed to ensure the facility implemented its policy and procedures to prevent neglect of client A in regard to a pressure ulcer. The governing body failed to ensure the facility put corrective measures in place to prevent recurrence of pressure ulcers with a client who had history of ulcers. The governing body failed to ensure the facility's nursing services met the health care needs of client A, and to ensure nursing services trained facility staff to meet the health care needs of the client and to conduct quarterly nursing assessments. The governing body failed to ensure the facility obtained the services of a Registered Nurse to consult and oversee the Licensed Practical nursing staff to ensure the health needs of clients were met. Findings include: 1. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for 1 of 3	W0102	**CONDITION**- Please refer to tag **W122, W318, and W104**	01/04/2013

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	sampled clients (A). The governing body failed to implement its written policies and procedures to prevent neglect of a client in regard to a pressure ulcer. The governing body failed to put in place corrective measures to prevent recurrence of ulcers. Please see W122. 2. The governing body failed to ensure the facility met the Condition of Participation: Health Care Services for 2 of 3 sampled clients (A and B). The governing body failed to ensure the facility's Health Care Services met the nursing needs of each client. The governing body failed to ensure the facility's Health Care Services trained staff in regard to clients' health care needs, to ensure risk plans addressed all the health care needs of clients including nursing measures staff were to follow in regard to wound care and repositioning. The facility's governing body failed to ensure facility staff reported all health concerns to nursing staff and/or documented medical/health needs. The governing body failed to ensure nursing services assessed and monitored the clients' health/medical needs at the group home and conducted quarterly nursing assessments. Please see W318. 3. The governing body failed to ensure nursing services met the healthcare needs			

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	of clients A and B. The governing body failed to ensure nursing services monitored the client's health needs, assessed a client's pressure ulcer, put in place specific risk plans to meet the health care needs of the client, to ensure facility staff documented medications correctly on the Medication Administration Record and completed skin assessments/body checks. The governing body failed to ensure nursing services adequately trained staff to provide care/treatment of pressure ulcers for client A. The governing body failed to ensure the facility's nursing services conducted quarterly nursing assessments for client B who did not require a nursing care plan. The governing body failed to ensure nursing services trained staff in regard to wound care/pressure ulcers for client A. The governing body failed to ensure a Registered Nurse was available for consultation and oversight of the Licensed Practical Nurses to ensure they provided nursing services to meet client A's healthcare needs in regard to pressure ulcers. Please see W104. This federal tag relates to complaint #IN00119881. 9-3-1(a)			

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W0104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 2 of 3 sampled clients (A and B), the governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to prevent neglect of client A in regard to a pressure ulcer. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility put corrective measures in place to prevent recurrence of pressure ulcers with a client who had a history of ulcers. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services met the health care needs of client A, and to ensure nursing services trained facility staff to meet the health care needs of the client and to conduct quarterly nursing assessments. The governing body failed to exercise general policy and operating direction over the facility to ensure facility obtained the services of a Registered Nurse to consult and oversee the Licensed Practical nursing staff to ensure the health needs of clients were met.	W0104	Please refer to tags **W149**, **W157**, **W331**, **W342**, and **W336**	01/04/2013

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	Findings include: 1. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented written policy and procedures to prevent neglect of a client who had a history of pressure ulcers. The governing body failed to put in place measures to prevent potential harm and/or recurrence. The governing body failed to ensure nursing services met the health care needs of clients and to ensure staff were adequately trained to provide wound care for client A. Please see W149. 2. The governing body failed to exercise general policy and operating direction over the facility to ensure its investigation included corrective/preventative measures to prevent recurrence for client A. Please see W157. 3. The governing body failed to exercise general policy and operating direction over the facility to ensure nursing services met the healthcare needs of clients A and B. The governing body failed to exercise general policy and operating direction over the facility to ensure nursing services monitored the client's health needs, assessed a client's pressure ulcer, put in place specific risk plans to meet the health care needs of the client, to ensure facility			

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	staff documented medications correctly on the Medication Administration Record and completed skin assessments/body checks. The governing body failed to exercise general policy and operating direction over the facility to ensure nursing services adequately trained staff to provide care/treatment of pressure ulcers for client A. Please see W331. 4. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services conducted quarterly nursing assessments for client B who did not require a nursing care plan. Please see W336. 5. The governing body failed to exercise general policy and operating direction over the facility to ensure nursing services trained staff in regard wound care/pressure ulcers for client A. Please see W342. 6. The governing body failed to exercise general policy and operating direction over the facility to ensure a Registered Nurse was available for consultation and oversight of the Licensed Practical Nurses to ensure they provided nursing services to meet client A's healthcare needs in regard to pressure ulcers. Please see W346.			

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	This federal tag relates to complaint #IN00119881. 9-3-1(a)			

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W0122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review, observation and interview, the facility failed to meet the Condition of Participation: Client Protections for 1 of 3 sampled clients (client A). The facility neglected to implement its policy and procedures to prevent neglect of client A in regard to the client's pressure ulcers as the client had a history of pressure ulcers. The facility neglected to prevent potential harm and/or recurrence. Findings include: 1. The facility neglected to implement its written policy and procedures to prevent neglect of client A, who had a history of pressure ulcers. The facility neglected to put in place measures to prevent potential harm and/or recurrence. The facility neglected to ensure nursing services met the health care needs of clients and to ensure staff were adequately trained to provide wound care. Please see W149. 2. The facility failed to ensure its investigation included corrective/preventative measures to prevent recurrence of pressure ulcers for client A. Please see W157.	W0122	**W122- CONDITION-** Also for W 149 - The Arc NWI policy for handling cases of Neglect and abuse Reviewed 2/15/12 does include "depriving a client of … medical care/treatment… not providing adequate personal care" within its definition of Neglect. As it is impossible to identify all the ways in which a person can be denied medical care/treatment the vagueness of the statement is appropriate. In addition to this policy a work instruction on the prevention and monitoring Pressure sores was developed on 12/7/12. This policy will be revised further to include the identification of all at risk persons, identify methods of preventing skin break down for at risk persons, and will identify measures to be taken for individuals being treated for skin break down. It will be completed by 1/13/13 Also for W 157 – Investigation 18609 corrective/ preventative measures was completed on 12/12/12. Recommendations were for the IDT to meet and revise Client A's repositioning risk plan. The IDT met on 12/12/12 and revised the plan. Beginning 12/12/12 The Behavior Health Director or his designee will review all investigations to	01/04/2013

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	This federal tag relates to complaint #IN00119881. 9-3-2(a)		ensure that Corrective and preventative measures are included in the conclusion. The Management review team reviewed a sample of investigations on a quarterly basis to ensure compliance with policy and procedures. Also for W 331 Community Services Nurse will assess a client's injury/skin breakdown within 24 hours of report. In the event that the individual is at risk for skin break down a work instruction on the prevention and monitoring Pressure sores was developed on 12/7/12. This policy will be revised further to include the identification of all at risk persons, identify methods of preventing skin break down for at risk persons, and will identify measures to be taken for individuals being treated for skin break down. It will be completed by 1/13/13. Client A's risk plan was revised on 12/12/12. To prevent further oversight the quarterly Nursing assessment was revised to include monitoring of risk plans. It was also revised to include an evaluation of the frequency of future nursing assessments. Work instructions for this nursing assessment will be revised by 1/31/13. The service coordinator will monitor that quarterly nursing assessments were completed on a quarterly basis. Direct care staff were retrained	

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			on documenting medication changes on all clients' MARs following each medication change on 12/11/12. Following any change DSPs are to fax the MAR to the nurse for review. To ensure future compliance all the MARs are reviewed by the Community services nurse on a monthly basis. Direct care staff were retrained on documenting on the skin assessments/body checks on 12/11/12. These documents are to be faxed into the nurse on a weekly basis for review and then forwarded to the service coordinator. To ensure future compliance the service coordinator will track the completion of these forms to ensure that no skin assessment/body check is missed on a weekly basis. Also for 336 Quarterly nursing assessments for client B was completed on 12/8/12. All other clients nursing assessments were also completed in December 2012. The quarterly Nursing assessment was revised to include monitoring of risk plans. It was also revised to include an evaluation of the frequency of future nursing assessments. Work instructions for this nursing assessment will be revised by 1/31/13. To ensure future compliance the service coordinator will monitor that quarterly nursing	

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			assessments were completed on a quarterly basis.	

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W0149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review, observation and interview for 1 of 3 sampled clients (A), the facility neglected to implement written policy and procedures to prevent neglect of a client who had a history of pressure ulcers. The facility neglected to put in place measures to prevent potential harm and/or recurrence. The facility neglected to ensure nursing services met the health care needs of clients and to ensure staff were adequately trained to provide wound care. Findings include: A review of the facility's records was conducted at the facility's administrative office on 12/5/12 at 12:45 P.M.. Review of the facility's investigation records indicated: "'Investigation Fact Sheet: Summary and Conclusion': Incident Report Number: 18609: Allegation: Neglect failing to document skin assessment sheets by staff for consumer wound on buttocks area...Facts supporting the allegation: All staff stated that they stopped doing skin assessments (sic) check sheets. (sic) When notified that the wound healed by	W0149	The Arc NWI policy for handling cases of Neglect and abuse Reviewed 2/15/12 does include "depriving a client of … medical care/treatment… not providing adequate personal care" within its definition of Neglect. As it is impossible to identify all the ways in which a person can be denied medical care/treatment the vagueness of the statement is appropriate. In addition to this policy a work instruction on the prevention and monitoring Pressure sores was developed on 12/7/12. This policy will be revised further to include the identification of all at risk persons, identify methods of preventing skin break down for at risk persons, and will identify measures to be taken for individuals being treated for skin break down. It will be completed by 1/13/13	01/04/2013

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	the nurse. They started back doing the assessments when notified by MEMO on 10/22/12 that they should not have stopped...Facts not supporting this allegation: [Direct Support Professional (DSP) #14] stated that she didn't receive a memo from the nurse regarding skin assessment checks...All the staff that was (sic) interviewed stated that they were under the impression that they could stop doing the skin assessment sheets, because the wound had healed, until they received a memo on 10/22/12 stated that they shouldn't have stop (sic) doing the skin assessment sheets and needed to start back...All staff was (sic) unaware of the second injury until they receive (sic) a memo on 11/8....The nurse [Licensed Practical Nurse (LPN) #1] stated that 'she told a few people that she wanted to stop the skin assessment checks, but she didn't get back to the staff to let them know that she wanted to continue the skin assessment checks.'" Further review of the investigation record indicated: "Incident/Accident Report' dated 11/12/12...Time 9:00 A.M....I was made aware of this incident on this consumer after which I had sent him to the wound clinic on 11/8/12. While doing a routine body check, the doctor found a 0.7 x 0.4 x			

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	0.1 cm (centimeter) pressure wound on his left ischium (buttock). On Oct. 22, 2012 staff was instructed to continue with doing the skin assessment sheets. Staff fail (sic) to document any wound findings....He is being seen by [Physician name] in the wound clinic every Thursday....Cause of this Incident/Accident: Factors that can lead to a pressures (sic) ulcer are incontinentance (sic) and limited mobility....What measure(s) do you think could prevent reoccurrence of this Incident/Accident?: Prior to this incident there was a memo sent out to the house in regards to not receiving the skin assessment sheets on a daily bas (sic) on this consumer. The skin assessment sheets had not been discontinued therefore assessments should have been continuing if this was done this would (sic) could have been prevent (sic)....Action taken (treatment, intervention, referrals, etc.) Describe briefly: Weekly wound clinic visits with staff treating per doctors orders. Staff observing for signs of infection and report to the nurse." Bureau of Developmental Disabilities Services (BDDS) report dated 11/8/12...Date of Knowledge: 11/8/12...Submitted Date: 11/9/12: "[Client A] was on scheduled medical			

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	appointment to the wound clinic for a blister on his foot. Staff at the wound clinic performed a routine body check and found a 0.7 x 0.4 x 0.1 cm pressure wound on his left ischium (buttocks)." BDDS report dated 11/8/12...Date of Knowledge: 11/12/12...Submitted date: 11/16/12: "I (LPN #1) was made aware of this incident on this consumer after which I had sent him (client A) to the wound clinic on November 8, 2012. While doing a routine body check the doctor found a 0.7 x 0.4 x 0.1cm pressure wound on his left ischium (buttock). On October 22, 2012 staff was instructed to continue with doing the skin assessment sheets which staff failed to document any wound findings....Plan to Resolve: Weekly wound clinic visits will occur. Staff are to observe for signs of infection and report to the nurse. 8 staff were removed from the schedule and a (sic) internal investigation is being conducted by the agency....Results will follow investigation." Further review of the BDDS reports failed to indicate a follow up report with the results of the investigation. "Interview Fact Sheet" dated 11/16/12: [LPN #1]: "I was off duty from Nov. 7-12, 2012. I gave no special instructions concerning this consumer (client A) in			

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	regards to skin assessments to the nurses. When (sic) I mention (sic) to a few people that I wanted to stop doing the daily skin assessments but I have not done so. I did fail to get back to those two people to let them know that the assessment skin sheets were to be continued until further notice. There is no rule in writing that says the other nurses are to go out to my houses when I'm on vacation or just out of the office. We are required to only cover the house and clients. We do what is necessary for the consumers in a case of emergency." "Interview Fact Sheet" dated 11/16/12: [LPN #2]: "I didn't receive any instructions from the nurse (LPN #1) regarding [client A] or the Mississippi house regarding skin assessment check sheet." "Interview Fact Sheet" dated 11/16/12: [LPN #3]: "I was not given any instructions for [client A] skin check while central team nurse was out of office on 11/7/12, 11/8/12, & 11/9/12." "Interview Fact Sheet" dated 11/16/12: [DSP #10] time 10:00 A.M.: "[Client A] have (sic) not had a bed sore. He had just got (sic) it. We got an e-mail from the nurse on 11/10/12 saying he had new meds for his butt the cream is suppose			

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	(sic) to go (sic) [client A] on Saturday, Monday and Wednesday. [Client A] (sic) wound went away. We got an e-mail saying that the wound was gone (sic) that e-mail was sent on 9/22/12 from the nurse it was not stated if the nurse wanted us to keep doing the skin assessment sheet (sic). On 10/22/12 that's (sic) when the nurse send and (sic) e-mail saying we need to do an (sic) skin assessment sheet on [client A] again. On the 11/10 (sic) that's (sic) when staff find (sic) out about the new wound and meds. I was still checking [client A] for wound (sic) the only wound staff know (sic) about was the wound on his right feet (sic). While cleaning [client A] up from being (sic) his butt was that red (sic) I never saw a wound on him to (sic) the email was sent on 11/10/12. Before 11/10/12 [client A] (sic) butt was not red. I never saw a wound. Staff was thinking it was because he sit (sic) at workshop for a long time and the wound be (sic) wet sometime for (sic) coming leaving work. Also dealing with [client A] his (sic) doesn't like anything on him at night. I wash [client A] or bath (sic) him every night before leaving if notice (sic) something on [client A] I would send and (sic) email. Staff never know (sic) about the wound (sic) the butt was just red. Staff was thinking it was because he would bed (sic) soaking wet coming home from			

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	workshop." "Interview Fact Sheet" dated 11/16/12: [DSP #11] time 11:00 A.M.: "[Client A] had one sore and it healed, staff wasn't given notice to stop or keep going on with skin graph sheets. Client had a sore on his right foot which was being treated and nurse knew about it. Nurse only came to the house once which was to watch another staff do a med pass and she looked at the client (sic) foot. From that day client didn't have a (sic) open sore on his behind. It was a surprise when we got a (sic) email about the sore on his behind. That's when we were given orders to treat the sore with a med called Cellerate which started on 11/10/12, and given again on 11/12/12, and 11/14/12, and that what was followed and given because I gave it to him on the 10th the first day. In August we receive (sic) a (sic) email on doing good on the client (sic) sore and that he was released from the wound clinic. The nurse gave instructions on just putting triple antibiotic ointment on the sore." "Interview Fact Sheet" dated 11/16/12: [DSP #12] time 12:00 P.M.: "On Oct. 22 I did not work. (sic) With [client A]'s last wound we were all told that we the staff needed to fill out an assessment sheet regarding [client A]'s wound. Once it was			

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	healed we received an email stating that it was healed and that staff did a great job. After that we staff concluded that [client A] no longer had a wound and the nurse did not tell us that we needed to continue. About 2-3 weeks ago I was told by my co-worker that we needed to continue doing assessment sheets and so I have. Regarding the wound that [client A] has on his buttocks currently, I became aware of this about one weeks (sic) ago after he had been seen by the wound clinic and we received an email that staff were to apply his cream and bandage every 3 days and keep him dry at all times. The assessment sheet (sic) are given to the nurse through the inter-office mail. Any paperwork that is filled out by all staff and then put in a mail box on the desk (sic). All staff are responsible for making sure that the mail gets taken in. Whoever is working in the mornings during the week before consumers leave for workshop separates the mail into the envelopes and label (sic) them to whoever they go to. The mail is then put in the orange bag behind [client A]'s wheelchair. My schedule at Mississippi is on Thurs. from 10 p.m.-Fri. 8 a.m., Fri. 11 p.m.-Sat. 8 a.m., Sat. 11 p.m.-Sun. 8:30 a.m.. I have done body checks for [client A] prior to the weekend of the 9th. When I came in that weekend (of the 9th) to work he had already been seen by the doc (doctor) and we received			

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	the instructions to apply the cream every 3 days and keep him dry at all times." "Interview Fact Sheet" dated 11/16/12: [Group Home Lead (GHL)] at 1:00 P.M.: "Sometime in Sept.- [client A] had a wound- staff was notified of following treatment and med topicals and bandage to apply. Nurse note to follow. All was going well where (sic) staff received an email saying [client A] was all healed up- we (sic) happy to know that, body check-no stop instruction was given from the nurse-then a few days nurse was requesting the daily checklist and we did that til further notice. My shift time (sic) are 5 a.m. to 8 a.m.-5 p.m. to 10:45 p.m. 5 days. Body check sheets are sent daily in manilla envelopes which is (sic) directed to nurse. All staff is (sic) responsible for delivery of mail to Main (main office). I do not recall the memo but was informed by the nurse to continue body checklist. Was told that client [client A] had a wound due to his visit at the wound check. I did not do a body check sheet because the person who was taking care, did them early in the a.m. All email-memo-are printed out, med memo to med book and any information in the communication book- also there is a (sic) email notebook for staff to read daily. Some memo (sic) require signing. I don't recall having to sign any memo on [client			

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	A]. I think we might need more communication-not just by email but maybe a personal visit by the nurse-she only communicate (sic) to the house and it was note for [client A]- a phone call-direct communication may be stop some miscommunication (sic). As far as staff and facility are doing a great job and best at their job (sic). I'm a little computer slow- and staff has help (sic) me a lot. Also I was told to send so many e-mail (sic) a week to complete." "Interview Fact Sheet" dated 11/16/12: [DSP #2] at 2:45 P.M.: "I worked on Wednesday 4-10 P.M. one day a week. I received memo about 2 or 3 months ago from nurse regarding the assessment sheet to check [client A] from head to toe every night. I checked [client A] on the night I (sic) when he came in from w.s (workshop) and when it was time for him to go to bed. I did not notice any unusual marks on him except the one on his right foot and that was already sent in to the nurse (sic) when I work it's my responsibility to turn in assessment check sheet inter office mail and put in out going mail slot. When received memo wounds (sic) was clearing. I was under the impression we have to do assessment sheet for [client A] when a memo stating we were not to stop assessment when I started assessment sheet again. I			

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	informed that everyday as soon as you come in check emails, communication book, (sic) information book. It's (sic) not a sign in the house stating that you should sign an email or memo when need it. When I came to work last Wed. I was informed that [client A] had a new wound and we should put his cream on it." "Interview Fact Sheet" dated 11/16/12: [DSP #13]: "I work Mon, Tues, Wed. 10:00 P.M. to 8:30 A.M.. No I have not observed any wounds on [client A]. Yes I do recall seeing a skin check memo on [client A] back in September. I do recall [client A] going to the wound clinic and that it was taken care of. I was told that after [client A] went to wound clinic that we were to discontinue putting bandage on [client A]. Once I am done with skin assessment it is left on desk with daily logs and green sheet. No there is not a procedure for reading memo (memos are usually printed and left for staff to read in file cabinet). The only marks (sic) that I have seen on [client A] was documented (right foot). At anytime while working with [client A] I have seen any new marks on [client A] noted per investigator he informed me that he didn't do anymore skin assessment checks after the first womb (sic) healed on 10/22/12." "Interview Fact Sheet" dated 11/16/12:			

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	[DSP #14] phone interview: "[DSP #14] works Sat. and Sun. 7 A.M.-11 P.M.. [DSP #14] stated that 'She did receive a memo from the nurse regarding checking him (client A) on the skin assessment sheet.' [DSP #14] said that she stop (sic) doing the skin assessment sheet because the woumb (sic) was healed. She started back once it was reported on 11/8 to start back doing the skin assessment sheet." "Interview Fact Sheet" dated 11/16/12: [DSP #15]: "Sunday 11/11/12-I worked at Mississippi from 8:30 A.M. til 10 P. M.. I asked other staff if anyone need change (sic) or any work need to be done before we went to church. Only work to (sic) Mississippi Sunday, did not do skin assessment check. Any noticible (sic) open sore, nurse conducted (sic), fill out assessment sheet then either fax it to the nurse or be sent to the nurse. Did not see memo but notified by co-worker about the body check, do not remember when I received the information." Further review of the investigation record indicated: "Conclusion: Parts of this allegation is (sic) true (sic) staff forgot to do skin assessment checks. The nurse [LPN #1] was unclear with her instructions to staff regarding the skin assessment checks.			

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	She didn't tell staff to continue or discontinue checking the buttock. Once the wound was healed around September 22, 2012 (sic). Therefore, staff assume (sic) that they wasn't suppose (sic) to continue skin assessment checks until the email dated 10/22/12 stated that they should have continue (sic) doing the skin assessment checks....Recommendations: Skin assessments were completed. Further however, not showing anything in the area in this investigation (sic). A system for ongoing wounds and other skin conditions needs to be discussed." The investigation indicated the document was signed and dated by the facility's administrator on 11/16/12. Further review of the investigation record indicated the facility neglected to indicate as of 12/7/12 what measures/recommendations/corrective actions would be put in place to prevent potential harm and/or recurrence. An evening observation was conducted at the group home on 12/5/12 from 5:10 P.M. until 8:10 P.M.. During the entire observation period client A utilized a wheelchair for mobility and was not encouraged and/or redirected to an alternate surface or position. A review of client A's record was conducted at the facility's administrative			

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	office on 12/6/12 at 11:22 A.M.. Review of client A's wound clinic records indicated he had a history of pressure ulcers from 3/12 to 9/20/12. Review of the Wound Clinic records indicated the following: Wound clinic notation dated 9/20/12: "Wound Clinic: Now healing wound left ischial and groin wounds now healed." Wound clinic notation dated 11/8/12: "Wound Clinic: Left ischial wound...0.7 x 0.4 x 0.1cm...90% pink 10% yellow...Foot- 0.7 x 0.3 x 0.1...Non-healing left ischial wound and right heel wound." Further review of the record failed to indicate any nursing reassessment of the size, shape and color of the wound, changing of dressing or documentation by facility nursing staff of client A's wound. Wound clinic notation dated 11/15/12: "Wound Clinic: Non-healing wounds...Right heel scabbed over...left ischial wound 0.6 x 0.5 x 0.1cm...Cellerate to ischial wounds every other day...return in 1 week." Further review of the record failed to indicate any nursing reassessment of the size, shape and color of the wound, changing of dressing or documentation by facility nursing staff of client A's wound.			

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	Wound clinic notation dated 11/29/12: "Wound Clinic: Non-healing wounds...left ischial wound 0.6 x 0.4 x 0.1cm...Cellerate to ischial wound every other day...return in 1 week...stage 2 pressure ulcer." Further review of the record failed to indicate any nursing reassessment of the size, shape and color of the wound, changing of dressing or documentation by facility nursing staff of client A's wound. The 11/29/12 Patient Visit Instructions Details sheet (physician's orders) indicated "Wound Cleansing Dressing: Remove old dressing...Cleanse the wound with normal saline prior to applying a clean dressing using gauze sponges, not tissues or cotton balls. Do not scrub or use excessive force. Pat dry using gauze sponges, not tissue or cotton balls. Protect wound and dressing and may take shower. Keep dressing dry and intact. Change dressing every other day. Cellerex applied do not wipe off. Apply new ointment each dressing change." Multi Wound Chart dated 12/6/12: "Wound Location: Left ischial. Wound Type: Pressure Ulcer. Date Acquired: 7/12/12. Wound Status; Not Healed. Measurements: 0.4 x 0.4 x 0.1 cm. Stage: Stage 2."			

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	A review of the group home Medication Administration Record (MAR) book was conducted on 12/5/12 at 6:00 P.M.. Review of the record indicated: "Health and Safety Memo" dated 10/31/12, from LPN #1 to group home staff : "Please handle the treatment for [client A]'s right foot as follows: Cleanse foot with peroxide. Apply triple antibiotic ointment to area. Put a bandage on the area. Keep site clean and dry. If skin begins to break down notify me immediately." "Health and Safety Memo" dated 11/8/12 from LPN #1 to group home staff: "[Client A] was seen at the wound clinic today for 2 wounds. One on his right foot and one above his left buttocks. He came back with the following orders: For the right foot wound: Aquacel dressing applied to wound-DO NOT REMOVE THE DRESSING- Do not get the dressing wet-Cover the dressing while bathing...For the left ischial (buttocks) wound: Cellerex applied today by wound clinic. Keep area clean and dry. Cover while bathing. New Cellerex to be applied every other day, starting Saturday, 11/10/12. Remove dressing, pat wound with a damp gauze, then pat dry with a dry gauze. DO NOT WIPE OFF THE			

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	OLD MEDICATION. Apply new layer of Cellerex and cover with a clean dressing. Keep area clean and dry. Cover while bathing. This is to be done EVERY OTHER DAY (Saturday, Monday and Wednesday) he'll return to the wound clinic on Thursday." "Health and Safety Memo" dated 11/30/12 from LPN #1 to group home staff: "[Client A] was seen at the wound clinic on yesterday for 2 wounds. One on his right foot and one above his left buttocks (sic). He came back with the following orders: For the right foot wound: This area has been resolved. For the left ischial (buttock) wound: Cellerex applied on 11/29 by wound clinic. Keep area clean and dry. Cover while bathing. New Cellerex to be applied every other day. Remove dressing, pat wound with damp gauze, and then pat dry with dry gauze. DO NOT WIPE OFF THE OLD MEDICATION. Apply new layer of Cellerex and cover with a clean dressing. If you need more of the Cellerex please pharmacy and reorder. Please call with any questions." Further review of the record conducted on 12/5/12 at 6:00 P.M., indicated a most current MAR dated 12/1/12 until 12/31/12. Review of the MAR indicated: "Mupirocin 2% ointment: Bactroban 2%			

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	ointment...Apply to wound topically once daily as directed." Further review indicated this medication was administered on 12/1/12, 12/3/12, 12/4/12 and 12/5/12. This medication was not administered on 12/2/12. The record failed to indicate which wound this ointment was to be applied to. Further review of the MAR did not have Cellerex, saline solution and gauze squares listed on MAR. The record indicated a most current "Health Risk Plan" for client A dated 1/17/12 which indicated: "Client is at risk for skin breakdown related to incontinence and decreased activity. Client is allergic to adhesives which can result in skin irritation. Client is a heavy wetter. Repositioned (sic) client every 4 hours and as needed. Position in another chair if possible. Check for incontinence every two hours and change as needed. Encourage client to change positions frequently. Apply treatment as ordered. Notify nurse of changes in skin condition immediately, if area becomes reddened, opens, bleeding, or irritated. Encourage client to use the bathroom every 2 hours during the day and at night. IDT (Inter Disciplinary Team) to review plan quarterly and revises as needed. Ensure client is using the correct size undergarment to avoid contact with adhesives. Service Coordinator to monitor behavior logs monthly and revise			

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	as needed. Nurse to monitor incident and accident reports and revise as needed." On 12/6/12 at 3:37 P.M.. SC #1 submitted a 5/12 "Repositioning Risk Plan". The 5/12 risk plan indicated; "[Client A] had a history of incontinence...Due to these conditions [client A] is at risk for skin breakdown related to immobility and incontinence. Baseline: [Client A] currently spends almost all the time he is awake in his wheelchair or bed. He needs to be transferred out of his chair and/or bed to relieve pressure on his back/buttocks as well as encourage muscle movement." The 5/12 risk plan indicated: "Staff are to notify the Nurse and the Service Coordinator of any redness, openings or bleeding is observed." The 5/12 risk plan neglected to indicate any additional information in regard to how facility staff were to care for the client's wound and/or how client A's wound was to be kept dry during showers. The facility's 5/12 risk plan also neglected to indicate when the facility reviewed and /or updated the client's risk plan to ensure the client's wound care needs. The Individual Support Plan (ISP) dated 3/21/12 indicated client A was at risk for skin breakdown. Client A's record neglected to indicate a			

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	repositioning/alternative seating schedule in place to prevent potential injury. The record neglected to indicate a current Physical Therapy (PT) assessment. The record neglected to indicate the facility obtained client A a wheelchair assessment. The most current "Nutritional Assessment" was dated 8/21/11. Client A's record neglected to indicate the IDT met regarding client A's wound care. A review of the group home daily progress notes dated 9/1/12 to 11/30/12 was conducted on 12/6/12 at 1:15 P.M.. The 11/25/12 progress note indicated: "Ate breakfast, showered took a.m. meds. Relaxed watched t.v. after goals. After lunch, hygiene, took noon med, took a nap. He was changed for dinner, sore on butt was redressed. He clean (sic) for bed, took HS (bedtime) meds, went to sleep...Checked him every two hours changed him as needed." Further review indicated no documentation was completed on 11/1/12, 11/7/12, 11/8/12, 11/9/12, 11/10/12, 11/17/12, 11/18/12, 11/21/12, 11/22/12, 11/23/12 and 11/30/12. Review of the records neglected to indicate group home staff documented any medical status in regards to client A's wound daily. A review of the facility's group home staff			

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	training records was conducted on 12/6/12 at 1:54 P.M.. Review of the 8/15/12 "Wound Care Training" neglected to indicate DSP #2, DSP #12 and DSP #15 had been trained in regards to wound care. The facility neglected to document any additional training in regards to wound care since 8/15/12. An interview with DSP #2 was conducted at the group home on 12/5/12 at 6:18 P.M. and 6:34 P.M.. DSP #2 indicated client A received treatments to the wound on his buttocks on Mondays, Wednesdays and Saturdays at bedtime. DSP #2 indicated if the client was wet they would change the bandage when he was toileted. When DSP #2 was asked if staff at the group home were applying the Cellerex or Mupirocin to client A's wound, DSP #2 indicated the Cellerex was being applied. When asked what the Mupirocin was being administered for, DSP #2 indicated the Mupirocin was applied to client A's wound. An interview with the group home Team Lead (TL) was conducted at the group home on 12/5/12 at 6:47 P.M.. The TL indicated Cellerex was being applied to client A's wound. When asked what Mupirocin was being applied to, the TL stated "His bottom." When asked if the Mupirocin was the same as the Cellerex,			

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	the TL stated "I'm not sure." When asked to see the Cellerex and the Mupirocin, DSP #2 and the group home TL were not able to locate the medications in the medication file cabinet until 7:15 P.M.. The Cellerex medication ointment tube was found in a clear plastic bag, which contained packaged gauze squares. The Cellerex was not labeled. The Mupirocin was found in a labeled box which indicated it was to be applied topically to wound once daily. Confidential interview C stated client A's wound "was the size of a dime." Confidential interview C stated client A's wound "is still a little open." When confidential interview C was asked how often client A's wound area was changed, confidential interview C stated "Every other day. We check when he is toileted and checked when given shower and changed." Confidential interview C also indicated they use square gauze and tape. When asked when the staff was trained in regard to wound care, confidential interview stated "I read a memo." Confidential interview C indicated she did not attend the training because she was not notified of the training held about two months ago. When asked how often the nurse came to the group home, confidential interview C stated "I have never seen her at this group home."			

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	When asked how does the nurse know what the area looks like, confidential interview C stated "Good question, we email her skin graph sheets that only indicate where it is. We write more information on the daily log sheets." Confidential interview C indicated client A was repositioned out of his chair when he was toileted, and some time after he ate dinner they would take him out of his wheel chair and he was placed on the couch. When asked if staff documented when client A was taken out of his wheelchair, confidential interview stated "No." An interview with Service Coordinator (SC) #1 was conducted on 12/5/12 at 7:10 P.M. and 12/6/12 at 3:55 P.M.. The SC indicated the Cellerex was not on the MAR dated 12/1/12 to 12/31/12. When the SC was asked what the Mupirocin was being applied to, the SC stated "I don't know." The SC indicated the Cellerex should be listed on the MAR and the staff should document when the Cellerex is being applied. At that time the SC made a phone call. When she returned she indicated the nurse had previously told the staff to discontinue the Mupirocin and further indicated the Mupirocin should not be on the MAR. The SC indicated staff were probably applying the Cellerex but were			

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	documenting the Mupirocin instead. The SC then instructed staff to go find the box the Cellerex was in which she indicated should contain the label. The group home staff could not locate a box or a label. SC #1 indicated LPN #1 had conducted a meeting in regards to pressure ulcers and wound care at the beginning of November 2012. SC #1 further indicated there was no documentation in regards to the mentioned meeting. SC #1 indicated client A's IDT had not met to review and/or address client A's identified 11/8/12 pressure ulcer. SC #1 further indicated the IDT neglected to ensure sufficient measures and safeguards were put in place to prevent potential harm and/or recurrence. An interview with LPN #1 was conducted at the facility's administrative office on 12/6/12 at 10:38 A.M.. LPN #1 indicated she was not aware if the facility had a policy and procedure in regard to wound care. When asked if the facility had a policy on when to contact a nurse, LPN #1 stated "I have not seen one." An interview with LPN #1 - and SC #2 was conducted at the facility's administrative office on 12/6/12 at 2:26 P.M.. LPN #1 and SC #2 indicated client A had a pressure ulcer on his buttocks. LPN #1 indicated client A had a history			

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	of pressure ulcers as the client had a pressure ulcer which healed on 9/20/12. When asked how many wounds/areas client A was being treated for prior to 9/12, LPN #1 indicated client A had a wound on his buttocks. When LPN #1 reviewed the 9/9/12 "Nursing Quarterly Assessment", LPN #1 stated "Oh, he had two areas." LPN #1 indicated client A's current pressure ulcer reappeared 11/8/12 as the ulcer was found at the wound clinic while being treated for a pressure ulcer to his foot. LPN #1 stated "Cellerex is to be applied to [client A's] wound every third day, Mondays, Wednesdays and Saturdays." When asked what Mupirocin was used for, LPN #1 stated "I'm not sure what that is being used for." When LPN #1 reviewed the wound clinic physicians orders dated 11/15/12 and 11/29/12, LPN #1 then indicated the Cellerex should be applied every other day, and further indicated Cellerex should be on the current MAR. LPN #1 indicated the wound care nurse told her the Cellerex should be applied on Mondays, Wednesdays and Saturdays." When LPN #1 was asked if there was normal saline solution in the home, LPN #1 stated "No." LPN #1 indicated the wound care clinic nurse told her they did not need to use the normal saline solution for client A's wound. When asked if LPN #1 sought			

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	clarification from the attending physician as opposed to the wound care clinic nurse, LPN #1 stated "No." When asked if a gauze sponge and gauze square were considered the same thing, LPN #1 stated "I don't know, there are only gauze squares at the houses." LPN #1 then stated "They are not the same." When asked if LPN #1 had observed staff doing wound care treatment at the group home, LPN #1 indicated she observed treatments prior to 11/8/12. When asked if LPN #1 had seen client A's current wound as of 11/8/12, LPN #1 stated "No I have not, I have not been there yet." When asked how big client A's pressure ulcer was, LPN #1 stated "About the size of a quarter." LPN #1 indicated she was able to determine the size by reading client A's wound clinic notation dated 11/29/12. When LPN #1 was asked how often she went to the group home to assess clients, she stated "I was going quite often, but now I have slacked." LPN #1 indicated she assessed the clients every three months at the day program. LPN #1 indicated skin assessments were to be done by group home staff twice a day. LPN #1 indicated the facility staff were to send in the skin assessment sheets daily. LPN #1 indicated the skin assessment sheets did not give any information/description of the client's wounds, they only indicated the location			

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	of the wound and/or injury. When asked who documents the physicians orders and medications on the MAR, LPN #1 stated "Lead or staff." When asked who checks to make sure the MAR is documented correctly, LPN #1 stated "The fax to me (MAR) to make sure it is correct." LPN #1 indicated she had not seen client A's 12/2012 MAR. When asked how does staff keep the dressing dry during showering, LPN #1 stated staff were "covering with saran wrap from what I was told." LPN #1 indicated there was no written protocol for client A's wound to ensure the wound stayed dry. LPN #1 and SC #2 indicated client A could reposition himself. LPN #1 and SC #2 indicated client A's program plan neglected to specifically indicate when the client should be repositioned and/or what alternate surface should be utilized. LPN #1 and SC #2 indicated the wound clinic ordered a ROHO cushion and a hospital bed for client A due to his pressure ulcers. LPN #1 and SC #2 indicated client A received a ROHO cushion and bed on Monday (12/5/12). LPN #1 and SC #2 indicated the use of the adaptive equipment was not part of client A's program plan. LPN #1 stated client A's bed was "electrical" and further indicated staff were not to change the settings on the bed. When asked if staff had been trained on the use of the bed,			

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	LPN #1 stated "Not sure. I did not train them." LPN #1 indicated facility staff did not document any specific information in regards to client A's medical/wound status. LPN #1 indicated client A did not have a current PT assessment, wheelchair assessment or nutritional assessment in regards to client A's wound care needs. When asked if client A had an updated risk plan for skin breakdown, LPN #1 stated "I don't know, I don't have access to risk plans." When asked if nursing staff were involved and had input in the development of medical risk plans for clients, LPN #1 stated "No, the SC write all risk plans for all clients." When asked if the facility had a Registered Nurse available for oversight, LPN #1 and SC #2 stated "No." When asked who was providing oversight and direct supervision over the facility's LPN staff, LPN #1 stated "[Group Home Services Director name (GHSD)]." When asked if the GHSD was a RN, LPN #1 stated "No." An interview with the facility owned day program Service Coordinator (SC) and day program Direct Support Professional (DSP) #1 was conducted on 12/7/12 at 2:15 P.M.. Day program SC indicated the facility had not submitted a repositioning/alternative seating schedule for day program staff to document for			

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	client A. SC indicated the day program staff take client A out of his wheelchair and place him on a bean bag because client A complains of pain. When asked how often client A complained of pain, day program SC asked day program DSP #1 who stated "Several times a day, he states it feels like a needle. " An interview with client A was conducted on 12/7/12 at 2:20 P.M.. Client A indicated he stays in his wheelchair until he goes to bed. A review of the facility's "Policy for Handling Cases of Neglect and Abuse" dated 12/20/06 was completed at the facility's administrative office on 12/5/12 at 2:30 P.M., and indicated: "In order to protect the general welfare of the clients, ARC Northwest Indiana has in effect the following policy with regard to abuse, neglect or exploitation of clients by agency staff...prohibits all abuse, neglect and exploitation of our clients...Staff will immediately report any allegations of abuse, neglect or exploitation of our clients per agency reporting procedure...Neglect is defined as knowingly placing a client in a situation that poses a threat to his/her health and well being...Examples include, but are not limited to, depriving a client of food, clothing, shelter or medical care."			

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W0157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on interview and record review for 1 of 4 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to ensure its investigation included corrective/preventative measures to prevent recurrence for client A. Findings include: A review of the facility's records was conducted at the facility's administrative office on 12/5/12 at 12:45 P.M.. Review of the facility's investigation records indicated the following regarding client A: "'Investigation Fact Sheet: Summary and Conclusion': Incident Report Number: 18609: Allegation: Neglect failing to document skin assessment sheets by staff for consumer wound on buttocks area...Facts supporting the allegation: All staff stated that they stopped doing skin assessments (sic) check sheets. (sic) When notified that the wound healed by the nurse. They started back doing the assessments when notified by MEMO on 10/22/12 that they should not have stopped...Facts not supporting this allegation: [Direct Support Professional (DSP) #14] stated that she didn't receive a	W0157	Investigation 18609 corrective/ preventative measures was completed on 12/12/12. Recommendations were for the IDT to meet and revise Client A's repositioning risk plan. The IDT met on 12/12/12 and revised the plan. Beginning 12/12/12 The Behavior Health Director or his designee will review all investigations to ensure that Corrective and preventative measures are included in the conclusion. The Management review team reviewed a sample of investigations on a quarterly basis to ensure compliance with policy and procedures.	01/04/2013

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	memo from the nurse regarding skin assessment checks...All the staff that was (sic) interviewed stated that they were under the impression that they could stop doing the skin assessment sheets, because the wound had healed, until they received a memo on 10/22/12 stated that they shouldn't have stop (sic) doing the skin assessment sheets and needed to start back...All staff was (sic) unaware of the second injury until they receive (sic) a memo on 11/8....The nurse [Licensed Practical Nurse (LPN) #1] stated that 'she told a few people that she wanted to stop the skin assessment checks, but she didn't get back to the staff to let them know that she wanted to continue the skin assessment checks.'" Further review of the investigation record indicated: "Incident/Accident Report' dated 11/12/12...Time 9:00 A.M....I was made aware of this incident on this consumer after which I had sent him to the wound clinic on 11/8/12. While doing a routine body check, the doctor found a 0.7 x 0.4 x 0.1 cm (centimeter) pressure wound on his left ischium (buttock). On Oct. 22, 2012 staff was instructed to continue with doing the skin assessment sheets. Staff fail (sic) to document any wound findings....He is being seen by [Physician			

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	name] in the wound clinic every Thursday....Cause of this Incident/Accident: Factors that can lead to a pressures (sic) ulcer are incontinentance (sic) and limited mobility....What measure(s) do you think could prevent reoccurrence of this Incident/Accident?: Prior to this incident there was a memo sent out to the house in regards to not receiving the skin assessment sheets on a daily bas (sic) on this consumer. The skin assessment sheets had not been discontinued therefore assessments should have been continuing if this was done this would (sic) could have been prevent (sic)....Action taken (treatment, intervention, referrals, etc.) Describe briefly: Weekly wound clinic visits with staff treating per doctors orders. Staff observing for signs of infection and report to the nurse." Bureau of Developmental Disabilities Services (BDDS) report dated 11/8/12...Date of Knowledge: 11/8/12...Submitted Date: 11/9/12: "[Client A] was on scheduled medical appointment to the wound clinic for a blister on his foot. Staff at the wound clinic performed a routine body check and found a 0.7 x 0.4 x 0.1 cm pressure wound on his left ischium (buttocks)."			

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	15G313	A. BUILDING 00 B. WING	12/14/2012

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	BDDS report dated 11/8/12...Date of Knowledge: 11/12/12...Submitted date: 11/16/12: "I (LPN #1) was made aware of this incident on this consumer after which I had sent him (client A) to the wound clinic on November 8, 2012. While doing a routine body check the doctor found a 0.7 x 0.4 x 0.1cm pressure wound on his left ischium (buttock). On October 22, 2012 staff was instructed to continue with doing the skin assessment sheets which staff failed to document any wound findings....Plan to Resolve: Weekly wound clinic visits will occur. Staff are to observe for signs of infection and report to the nurse. 8 staff were removed from the schedule and a (sic) internal investigation is being conducted by the agency....Results will follow investigation." Further review of the BDDS reports failed to indicate a follow up report with the results of the investigation. Further review of the investigation record indicated: "Conclusion: Parts of this allegation is (sic) true (sic) staff forgot to do skin assessment checks. The nurse [LPN #1] was unclear with her instructions to staff regarding the skin assessment checks. She didn't tell staff to continue or discontinue checking the buttock. Once			

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	the wound was healed around September 22, 2012 (sic). Therefore, staff assume (sic) that they wasn't suppose (sic) to continue skin assessment checks until the email dated 10/22/12 stated that they should have continue (sic) doing the skin assessment checks....Recommendations: Skin assessments were completed. Further however, not showing anything in the area in this investigation (sic). A system for ongoing wounds and other skin conditions needs to be discussed." The investigation indicated the document was signed and dated by the facility's administrator on 11/16/12. Further review of the investigation record indicated the facility failed to indicate as of 12/7/12 what measures/recommendations/corrective actions would be put in place to prevent potential harm and/or recurrence of pressure ulcers for client A. An interview with Service Coordinator (SC) #1 was conducted on 12/5/12 at 7:10 P.M. and 12/6/12 at 3:55 P.M.. SC #1 indicated LPN #1 had conducted a meeting in regards to pressure ulcers and wound care at the beginning of November 2012. SC #1 further indicated there was no documentation in regards to the mentioned meeting. SC #1 indicated client A's IDT had not met to review and/or address client A's identified			

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	11/8/12 pressure ulcer. SC #1 further indicated the facility's IDT neglected to ensure sufficient measures and safeguards were put in place to prevent potential harm and/or recurrence. This federal tag relates to complaint #IN00119881. 9-3-2(a)			

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W0240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, interview and record review for 1 of 3 sampled clients (A), the client's Individual Program Plan (IPP) failed to indicate how and/or when facility staff were to reposition the client to prevent skin break down/pressure ulcers and/or how to keep the client's wound dry when showering. Findings include: A review of client A's record was conducted at the facility's administrative office on 12/6/12 at 11:22 A.M.. Review of client A's wound clinic records indicated he had a history of pressure ulcers from 3/12 to 9/20/12. Review of the Wound Clinic records indicated the following: Wound clinic notation dated 9/20/12: "Wound Clinic: Now healing wound left ischial and groin wounds now healed." Wound clinic notation dated 11/8/12: "Wound Clinic: Left ischial wound...0.7 x 0.4 x 0.1cm...90% pink 10% yellow...Foot- 0.7 x 0.3 x 0.1...Non-healing left ischial wound...."	W0240	This client's IPP will be updated to reflect his need for repositioning and pressure sore monitoring by 1/7/13. The service coordinator reviewed all other IPPs to ensure that they are current and accurate . To ensure future compliance, Service Coordinator and Individual Program Coordinator will monitor IPP folders to ensure they contain all information pertinent to individualized care for each client on a quarterly basis.	01/04/2013

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	Wound clinic notation dated 11/15/12: "Wound Clinic: Non-healing wounds...Right heel scabbed over...left ischial wound 0.6 x 0.5 x 0.1cm...Cellerate to ischial wounds every other day...return in 1 week." Wound clinic notation dated 11/29/12: "Wound Clinic: Non-healing wounds...left ischial wound 0.6 x 0.4 x 0.1cm...Cellerate to ischial wound every other day...return in 1 week...stage 2 pressure ulcer." The 11/29/12 Patient Visit Instructions Details (physician's orders) sheet indicated "Wound Cleansing Dressing: Remove old dressing...Cleanse the wound with normal saline prior to applying a clean dressing using gauze sponges, not tissues or cotton balls. Do not scrub or use excessive force. Pat dry using gauze sponges, not tissue or cotton balls. Protect wound and dressing and may take shower. Keep dressing dry and intact. Change dressing every other day. Cellerex applied do not wipe off. Apply new ointment each dressing change." An evening observation was conducted at the group home on 12/5/12 from 5:10 P.M. until 8:10 P.M.. During the entire observation period client A utilized a wheelchair for mobility and was not encouraged and/or redirected to an alternate surface or position.			

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	On 12/6/12 at 3:37 P.M.. SC #1 submitted a 5/12 "Repositioning Risk Plan". The 5/12 risk plan indicated; "[Client A] had a history of incontinence...Due to these conditions [client A] is at risk for skin breakdown related to immobility and incontinence. Baseline: [Client A] currently spends almost all the time he is awake in his wheelchair or bed. He needs to be transferred out of his chair and/or bed to relieve pressure on his back/buttocks as well as encourage muscle movement." The 5/12 risk plan did not indicate any additional information in regard to how/when facility staff were to reposition the client and/or indicate how client A's wound was to be kept dry during showers. Confidential interview C indicated client A was repositioned out of his chair when he was toileted, and some time after he ate dinner they would take him out of his wheel chair and he was placed on the couch. When asked if staff documented when client A was taken out of his wheelchair, confidential interview stated "No." An interview with LPN #1 and SC #2 was conducted at the facility's administrative office on 12/6/12 at 2:26 P.M.. LPN #1 and SC #2 indicated client A had a			

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	pressure ulcer on his buttocks. LPN #1 indicated client A had a history of pressure ulcers as the client had a pressure ulcer which healed on 9/20/12. When asked how does staff keep the dressing dry during showering, LPN #1 stated staff were "covering with saran wrap from what I was told." LPN #1 indicated there was no written protocol for client A's wound to ensure the wound stayed dry. LPN #1 and SC #2 indicated client A could reposition himself. LPN #1 and SC #2 indicated client A's program plan did not specifically indicate when the client should be repositioned and/or what alternate surface should be utilized. This federal tag relates to complaint #IN00119881. 9-3-4(a)			

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W0318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Health Care Services for 2 of 3 sampled clients (A and B). The facility's Health Care Services failed to ensure the facility's nursing services met the nursing needs of each client. The facility's Health Care Services failed to ensure the facility's nursing services trained staff in regard to clients' health care needs, to ensure risk plans addressed all the health care needs of clients including nursing measures staff were to follow in regard to wound care/pressure ulcers. The facility's Health Care Services failed to ensure facility staff reported all health concerns to nursing staff and/or documented medical/health needs. The facility's Health Care Services failed to ensure nursing services assessed, monitored the clients' health/medical needs at the group home and conducted quarterly nursing assessments. Findings include: 1. The facility's nursing services failed to meet the needs of the clients in regard to monitoring the clients' health needs, assessing a client's pressure ulcer, putting	W0318	**CONDITION**- Please refer to tag W331	01/04/2013

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	in place specific risk plans to meet the health care needs of clients, to ensure facility staff documented medications correctly on the Medication Administration Record and completed skin assessments/body checks. The facility's nursing services failed to ensure staff were adequately trained to provide care/treatment of pressure ulcers for client A. Please see W331. 2. The facility's nursing services failed to ensure staff were trained in regard to documenting medication changes on the Medication Administration record (MAR) and to ensure staff were trained in regard to documentation of the client's daily notes and/or body checks, and to ensure facility staff were trained/retrained to provide care for wounds/pressure ulcers for client A. Please see W342. 3. The facility's nursing services failed to ensure a registered nurse was available to consult and/or oversee licensed practical nurses to ensure nursing staff met the health care needs of a client in regard to pressure ulcers. Please see W346. 4. The facility's nursing services failed to conduct quarterly nursing assessments for client B who did not require a nursing care plan. Please see W336.			

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	This federal tag relates to complaint #IN00119881. 9-3-6(a)			

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W0331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 1 of 3 sampled clients (A), the facility's nursing services failed to meet the needs of the clients in regard to monitoring the client's health needs, assessing a client's pressure ulcer, putting in place specific risk plans to meet the health care need of a client, to ensure facility staff documented medications correctly on the Medication Administration Record and completed skin assessments/body checks. The facility's nursing services failed to ensure staff were adequately trained to provide care/treatment of pressure ulcers. Findings include: A review of the facility's records was conducted at the facility's administrative office on 12/5/12 at 12:45 P.M.. Review of the facility's investigation records indicated: "'Investigation Fact Sheet: Summary and Conclusion': Incident Report Number: 18609: Allegation: Neglect failing to document skin assessment sheets by staff for consumer wound on buttocks area...Facts supporting the allegation: All staff stated that they stopped doing skin	W0331	Community Services Nurse will assess a client's injury/skin breakdown within 24 hours of report. In the event that the individual is at risk for skin break down a work instruction on the prevention and monitoring Pressure sores was developed on 12/7/12. This policy will be revised further to include the identification of all at risk persons, identify methods of preventing skin break down for at risk persons, and will identify measures to be taken for individuals being treated for skin break down. It will be completed by 1/13/13. Client A's risk plan was revised on 12/12/12. To prevent further oversight the quarterly Nursing assessment was revised to include monitoring of risk plans. It was also revised to include an evaluation of the frequency of future nursing assessments. Work instructions for this nursing assessment will be revised by 1/31/13. The service coordinator will monitor that quarterly nursing assessments were completed on a quarterly basis. Direct care staff were retrained on documenting medication changes on all clients' MARs following each medication change on 12/11/12. Following any	01/13/2013

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	assessments (sic) check sheets. (sic) When notified that the wound healed by the nurse. They started back doing the assessments when notified by MEMO on 10/22/12 that they should not have stopped...Facts not supporting this allegation: [Direct Support Professional (DSP) #14] stated that she didn't receive a memo from the nurse regarding skin assessment checks...All the staff that was (sic) interviewed stated that they were under the impression that they could stop doing the skin assessment sheets, because the wound had healed, until they received a memo on 10/22/12 stated that they shouldn't have stop (sic) doing the skin assessment sheets and needed to start back...All staff was (sic) unaware of the second injury until they receive (sic) a memo on 11/8....The nurse [Licensed Practical Nurse (LPN) #1] stated that 'she told a few people that she wanted to stop the skin assessment checks, but she didn't get back to the staff to let them know that she wanted to continue the skin assessment checks.'" Further review of the investigation record indicated: "Conclusion: Parts of this allegation is (sic) true (sic) staff forgot to do skin assessment checks. The nurse [LPN #1] was unclear with her instructions to staff		change DSPs are to fax the MAR to the nurse for review. To ensure future compliance all the MARs are reviewed by the Community services nurse on a monthly basis. Direct care staff were retrained on documenting on the skin assessments/body checks on 12/11/12. These documents are to be faxed into the nurse on a weekly basis for review and then forwarded to the service coordinator. To ensure future compliance the service coordinator will track the completion of these forms to ensure that no skin assessment/body check is missed on a weekly basis.	

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	regarding the skin assessment checks. She didn't tell staff to continue or discontinue checking the buttock. Once the wound was healed around September 22, 2012 (sic). Therefore, staff assume (sic) that they wasn't suppose (sic) to continue skin assessment checks until the email dated 10/22/12 stated that they should have continue (sic) doing the skin assessment checks....Recommendations: Skin assessments were completed. Further however, not showing anything in the area in this investigation (sic). A system for ongoing wounds and other skin conditions needs to be discussed." An evening observation was conducted at the group home on 12/5/12 from 5:10 P.M. until 8:10 P.M.. During the entire observation period client A utilized a wheelchair for mobility and was not encouraged and/or redirected to an alternate surface or position. A review of client A's record was conducted at the facility's administrative office on 12/6/12 at 11:22 A.M.. Review of client A's wound clinic records indicated he had a history of pressure ulcers from 3/12 to 9/20/12. Review of the Wound Clinic records indicated the following: Wound clinic notation dated 9/20/12:			

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	"Wound Clinic: Now healing wound left ischial and groin wounds now healed." Wound clinic notation dated 11/8/12: "Wound Clinic: Left ischial wound...0.7 x 0.4 x 0.1cm...90% pink 10% yellow...Foot- 0.7 x 0.3 x 0.1...Non-healing left ischial wound and right heel wound." Further review of the record failed to indicate any nursing reassessment of the size, shape and color of the wound, changing of dressing or documentation by facility nursing staff of client A's wound. Wound clinic notation dated 11/15/12: "Wound Clinic: Non-healing wounds...Right heel scabbed over...left ischial wound 0.6 x 0.5 x 0.1cm...Cellerate to ischial wounds every other day...return in 1 week." Further review of the record failed to indicate any nursing reassessment of the size, shape and color of the wound, changing of dressing or documentation by facility nursing staff of client A's wound. Wound clinic notation dated 11/29/12: "Wound Clinic: Non-healing wounds...left ischial wound 0.6 x 0.4 x 0.1cm...Cellerate to ischial wound every other day...return in 1 week...stage 2 pressure ulcer." Further review of the record failed to indicate any nursing			

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	reassessment of the size, shape and color of the wound, changing of dressing or documentation by facility nursing staff of client A's wound. The 11/29/12 Patient Visit Instructions Details sheet (physician's orders) indicated "Wound Cleansing Dressing: Remove old dressing...Cleanse the wound with normal saline prior to applying a clean dressing using gauze sponges, not tissues or cotton balls. Do not scrub or use excessive force. Pat dry using gauze sponges, not tissue or cotton balls. Protect wound and dressing and may take shower. Keep dressing dry and intact. Change dressing every other day. Cellerex applied do not wipe off. Apply new ointment each dressing change." Multi Wound Chart dated 12/6/12: "Wound Location: Left ischial. Wound Type: Pressure Ulcer. Date Acquired: 7/12/12. Wound Status; Not Healed. Measurements: 0.4 x 0.4 x 0.1 cm. Stage: Stage 2." A review of the group home Medication Administration Record (MAR) book was conducted on 12/5/12 at 6:00 P.M.. Review of the record indicated: "Health and Safety Memo" dated 10/31/12, from LPN #1 to group home			

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	staff : "Please handle the treatment for [client A]'s right foot as follows: Cleanse foot with peroxide. Apply triple antibiotic ointment to area. Put a bandage on the area. Keep site clean and dry. If skin begins to break down notify me immediately." "Health and Safety Memo" dated 11/8/12 from LPN #1 to group home staff: "[Client A] was seen at the wound clinic today for 2 wounds. One on his right foot and one above his left buttocks. He came back with the following orders: For the right foot wound: Aquacel dressing applied to wound-DO NOT REMOVE THE DRESSING- Do not get the dressing wet-Cover the dressing while bathing...For the left ischial (buttocks) wound: Cellerex applied today by wound clinic. Keep area clean and dry. Cover while bathing. New Cellerex to be applied every other day, starting Saturday, 11/10/12. Remove dressing, pat wound with a damp gauze, then pat dry with a dry gauze. DO NOT WIPE OFF THE OLD MEDICATION. Apply new layer of Cellerex and cover with a clean dressing. Keep area clean and dry. Cover while bathing. This is to be done EVERY OTHER DAY (Saturday, Monday and Wednesday) he'll return to the wound clinic on Thursday."			

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	"Health and Safety Memo" dated 11/30/12 from LPN #1 to group home staff: "[Client A] was seen at the wound clinic on yesterday for 2 wounds. One on his right foot and one above his left buttocks (sic). He came back with the following orders: For the right foot wound: This area has been resolved. For the left ischial (buttock) wound: Cellerex applied on 11/29 by wound clinic. Keep area clean and dry. Cover while bathing. New Cellerex to be applied every other day. Remove dressing, pat wound with damp gauze, and then pat dry with dry gauze. DO NOT WIPE OFF THE OLD MEDICATION. Apply new layer of Cellerex and cover with a clean dressing. If you need more of the Cellerex please pharmacy and reorder. Please call with any questions. Thank you." Further review of the record conducted on 12/5/12 at 6:00 P.M., indicated a most current MAR dated 12/1/12 until 12/31/12. Review of the MAR indicated: "Mupirocin 2% ointment: Bactroban 2% ointment...Apply to wound topically once daily as directed." Further review indicated this medication was administered on 12/1/12, 12/3/12, 12/4/12 and 12/5/12. This medication was not administered on 12/2/12. The record failed to indicate which wound this ointment was to be applied to. Further			

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	review of the MAR did not have Cellerex, saline solution and gauze squares listed on MAR. The record indicated a most current "Health Risk Plan" for client A dated 1/17/12 which indicated: "Client is at risk for skin breakdown related to incontinence and decreased activity. Client is allergic to adhesives which can result in skin irritation. Client is a heavy wetter. Repositioned (sic) client every 4 hours and as needed. Position in another chair if possible. Check for incontinence every two hours and change as needed. Encourage client to change positions frequently. Apply treatment as ordered. Notify nurse of changes in skin condition immediately, if area becomes reddened, opens, bleeding, or irritated. Encourage client to use the bathroom every 2 hours during the day and at night. IDT (Inter Disciplinary Team) to review plan quarterly and revises as needed. Ensure client is using the correct size undergarment to avoid contact with adhesives. Service Coordinator to monitor behavior logs monthly and revise as needed. Nurse to monitor incident and accident reports and revise as needed." On 12/6/12 at 3:37 P.M.. SC #1 submitted a 5/12 "Repositioning Risk Plan". The 5/12 risk plan indicated; "[Client A] had a history of incontinence...Due to these conditions			

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	[client A] is at risk for skin breakdown related to immobility and incontinence. Baseline: [Client A] currently spends almost all the time he is awake in his wheelchair or bed. He needs to be transferred out of his chair and/or bed to relieve pressure on his back/buttocks as well as encourage muscle movement." The 5/12 risk plan indicated: "Staff are to notify the Nurse and the Service Coordinator of any redness, openings or bleeding is observed." The 5/12 risk plan failed to indicate any additional information in regard to how facility staff were to care for the clients wound and/or how client A's wound was to be kept dry during showers. The facility's 5/12 risk plan also failed to indicate when the facility reviewed and/or updated the client's risk plan to ensure the client's wound care needs. The Individual Support Plan (ISP) dated 3/21/12 indicated client A was at risk for skin breakdown. Client A's record neglected to indicate a repositioning/alternative seating schedule in place to prevent potential injury. The record failed to indicate a current Physical Therapy (PT) assessment. The record failed to indicate the nursing services obtained a wheelchair assessment for client A and/or a current "Nutritional Assessment" as the most current			

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	assessment was dated 8/21/11. Client A's record indicated the nursing services failed to develop a risk plan for client A's wound care. A review of the group home daily progress notes dated 9/1/12 to 11/30/12 was conducted on 12/6/12 at 1:15 P.M.. The 11/25/12 progress note indicated: "Ate breakfast, showered took a.m. meds. Relaxed watched t.v. after goals. After lunch, hygiene, took noon med, took a nap. He was changed for dinner, sore on butt was redressed. He clean (sic) for bed, took HS (bedtime) meds, went to sleep...Checked him every two hours changed him as needed." Further review indicated no documentation was completed on 11/1/12, 11/7/12, 11/8/12, 11/9/12, 11/10/12, 11/17/12, 11/18/12, 11/21/12, 11/22/12, 11/23/12 and 11/30/12. Review of the records indicated the group home staff failed to document any medical status in regards to client A's wound daily. A review of the facility's group home staff training records was conducted on 12/6/12 at 1:54 P.M.. Review of the 8/15/12 "Wound Care Training" neglected to indicate DSP #2, DSP #12 and DSP #15 had been trained in regards to wound care. Nursing Services failed to document and/or conduct any additional			

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	training in regards to wound care since 8/15/12. An interview with DSP #2 was conducted at the group home on 12/5/12 at 6:18 P.M. and 6:34 P.M.. DSP #2 indicated client A received treatments to the wound on his buttocks on Mondays, Wednesdays and Saturdays at bedtime. DSP #2 indicated if the client was wet they would change the bandage when he was toileted. When DSP #2 was asked if staff at the group home were applying the Cellerex or Mupirocin to client A's wound, DSP #2 indicated the Cellerex was being applied. When asked what the Mupirocin was being administered for, DSP #2 indicated the Mupirocin was applied to client A's wound. An interview with the group home Team Lead (TL) was conducted at the group home on 12/5/12 at 6:47 P.M.. The TL indicated Cellerex was being applied to client A's wound. When asked what Mupirocin was being applied to, the TL stated "His bottom." When asked if the Mupirocin was the same as the Cellerex, the TL stated "I'm not sure." When asked to see the Cellerex and the Mupirocin, DSP #2 and the group home TL were not able to locate the medications in the medication file cabinet until 7:15 P.M.. The Cellerex medication ointment tube			

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	was found in a clear plastic bag, which contained packaged gauze squares. The Cellerex was not labeled. The Mupirocin was found in a labeled box which indicated it was to be applied topically to wound once daily. Confidential interview C stated client A's wound "was the size of a dime." Confidential interview C stated client A's wound "is still a little open." When confidential interview C was asked how often client A's wound area was changed, confidential interview C stated "Every other day. We check when he is toileted and checked when given shower and changed." Confidential interview C also indicated they use square gauze and tape. When asked when the staff was trained in regard to wound care, confidential interview stated "I read a memo." Confidential interview C indicated she did not attend the training because she was not notified of the training held about two months ago. When asked how often the nurse came to the group home, confidential interview C stated "I have never seen her at this group home." When asked how does the nurse know what the area looks like, confidential interview C stated "Good question, we email her skin graph sheets that only indicate where it is. We write more information on the daily log sheets."			

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	Confidential interview C indicated client A was repositioned out of his chair when he was toileted, and some time after he ate dinner they would take him out of his wheel chair and he was placed on the couch. When asked if staff documented when client A was taken out of his wheelchair, confidential interview stated "No." An interview with Service Coordinator (SC) #1 was conducted on 12/5/12 at 7:10 P.M. and 12/6/12 at 3:55 P.M.. The SC indicated the Cellerex was not on the MAR dated 12/1/12 to 12/31/12. When the SC was asked what the Mupirocin was being applied to, the SC stated "I don't know." The SC indicated the Cellerex should be listed on the MAR and the staff should document when the Cellerex is being applied. At that time the SC made a phone call. When she returned she indicated the nurse had previously told the staff to discontinue the Mupirocin and further indicated the Mupirocin should not be on the MAR. The SC indicated staff were probably applying the Cellerex but were documenting the Mupirocin instead. The SC then instructed staff to go find the box the Cellerex was in which she indicated should contain the label. The group home staff could not locate a box or a label. SC #1 indicated LPN #1 had conducted a			

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	meeting in regards to pressure ulcers and wound care at the beginning of November 2012. SC #1 further indicated there was no documentation in regards to the mentioned meeting. An interview with LPN #1 was conducted at the facility's administrative office on 12/6/12 at 10:38 A.M.. LPN #1 indicated she was not aware if the facility had a policy and procedure in regard to wound care. When asked if the facility had a policy on when to contact a nurse, LPN #1 stated "I have not seen one." An interview with LPN #1 and SC #2 was conducted at the facility's administrative office on 12/6/12 at 2:26 P.M.. LPN #1 and SC #2 indicated client A had a pressure ulcer on his buttocks. LPN #1 indicated client A had a history of pressure ulcers as the client had a pressure ulcer which healed on 9/20/12. When asked how many wounds/areas client A was being treated for prior to 9/12, LPN #1 indicated client A had a wound on his buttocks. When LPN #1 reviewed the 9/9/12 "Nursing Quarterly Assessment", LPN #1 stated "Oh, he had two areas." LPN #1 indicated client A's current pressure ulcer reappeared 11/8/12 as the ulcer was found at the wound clinic while being treated for a pressure ulcer to his foot. LPN #1 stated "Cellerex is to be			

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	applied to [client A's] wound every third day, Mondays, Wednesdays and Saturdays." When asked what Mupirocin was used for, LPN #1 stated "I'm not sure what that is being used for." When LPN #1 reviewed the wound clinic physicians orders dated 11/15/12 and 11/29/12, LPN #1 then indicated the Cellerex should be applied every other day, and further indicated Cellerex should be on the current MAR. LPN #1 indicated the wound care nurse told her the Cellerex should be applied on Mondays, Wednesdays and Saturdays." When LPN #1 was asked if there was normal saline solution in the home, LPN #1 stated "No." LPN #1 indicated the wound care clinic nurse told her they did not need to use the normal saline solution for client A's wound. When asked if LPN #1 sought clarification from the attending physician as opposed to the wound care clinic nurse, LPN #1 stated "No." When asked if a gauze sponge and gauze square were considered the same thing, LPN #1 stated "I don't know, there are only gauze squares at the houses." LPN #1 then stated "They are not the same." When asked if LPN #1 had observed staff doing wound care treatment at the group home, LPN #1 indicated she observed treatments prior to 11/8/12. When asked if LPN #1 had seen client A's current wound as of 11/8/12, LPN #1 stated "No I have not, I			

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	have not been there yet." When asked how big client A's pressure ulcer was, LPN #1 stated "About the size of a quarter." LPN #1 indicated she was able to determine the size by reading client A's wound clinic notation dated 11/29/12. When LPN #1 was asked how often she went to the group home to assess clients, she stated "I was going quite often, but now I have slacked." LPN #1 indicated she assessed the clients every three months at the day program. LPN #1 indicated skin assessments were to be done by group home staff twice a day. LPN #1 indicated the facility staff were to send in the skin assessment sheets daily. LPN #1 indicated the skin assessment sheets did not give any information/description of the client's wounds, they only indicated the location of the wound and/or injury. When asked who documents the physicians orders and medications on the MAR, LPN #1 stated "Lead or staff." When asked who checks to make sure the MAR is documented correctly, LPN #1 stated "The fax to me (MAR) to make sure it is correct." LPN #1 indicated she had not seen client A's 12/2012 MAR. When asked how does staff keep the dressing dry during showering, LPN #1 stated staff were "covering with saran wrap from what I was told." LPN #1 indicated there was no written protocol for client A's wound to			

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	ensure the wound stayed dry. LPN #1 and SC #2 indicated client A could reposition himself. LPN #1 and SC #2 indicated the facility's nursing services failed to develop a repositioning schedule which indicated when the client should be repositioned, and/or indicate what alternate surface should be utilized. LPN #1 and SC #2 indicated the wound clinic ordered a ROHO cushion and a hospital bed for client A due to his pressure ulcers. LPN #1 and SC #2 indicated client A received a ROHO cushion and bed on Monday (12/5/12). LPN #1 and SC #2 indicated the use of the adaptive equipment was not part of client A's program plan. LPN #1 stated client A's bed was "electrical" and further indicated staff were not to change the settings on the bed. When asked if staff had been trained on the use of the bed, LPN #1 stated "Not sure. I did not train them." LPN #1 indicated facility staff did not document any specific information in regards to client A's medical/wound status. LPN #1 indicated client A did not have a current PT assessment, wheelchair assessment or nutritional assessment in regards to client A's wound care needs. When asked if client A had an updated risk plan for skin breakdown, LPN #1 stated "I don't know, I don't have access to risk plans." When asked if nursing staff were involved and had input in the			

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	development of medical risk plans for clients, LPN #1 stated "No, the SC write all risk plans for all clients." This federal tag relates to complaint #IN00119881. 9-3-6(a)			

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W0336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on interview and record review for 1 of 3 sampled clients (B), the facility's nursing services failed to conduct quarterly nursing assessments for clients who did not require a nursing care plan. Findings include: Client B's record was reviewed on 12/6/12 at 1:22 PM. Client B's record indicated a nursing quarterly examination/assessment was completed on 2/9/12. Client B's 1/11/12 Individual Program Plan (IPP) indicated the client did not require a medical care plan. Client B's 11/12 physician's orders indicated the client received routine medications. Client B's 11/12 physician's orders indicated client B's diagnoses included, but were not limited to, Neurological Disorders, Constipation, Hypertension, Gastroesophageal Reflux Disorder and Major Depressive Disorder. Interview with LPN #1 on 12/6/12 at 2:26 PM indicated quarterly nursing assessments/examinations should have been completed in 5/12 and 8/12. LPN #2	W0336	Quarterly nursing assessments for client B was completed on 12/8/12. All other clients nursing assessments were also completed in December 2012. The quarterly Nursing assessment was revised to include monitoring of risk plans. It was also revised to include an evaluation of the frequency of future nursing assessments. Work instructions for this nursing assessment will be revised by 1/31/13. To ensure future compliance the service coordinator will monitor that quarterly nursing assessments were completed on a quarterly basis.	01/04/2013

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated she could not locate any additional nursing quarterly assessments for the client. 9-3-6(a)			

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	15G313	A. BUILDING 00 B. WING	12/14/2012

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W0342	483.460(c)(5)(iii) NURSING SERVICES Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients. Based on observation, interview and record review for 1 of 3 sampled clients (A), the facility's nursing services failed to ensure staff were trained in regard to documenting medication changes on the Medication Administration record (MAR) and to ensure staff were trained in regard to documentation of the client's daily notes and/or body checks, and to ensure facility staff were trained/retrained to provide care for wounds/pressure ulcers. Findings include: A review of the facility's records was conducted at the facility's administrative office on 12/5/12 at 12:45 P.M.. Review of the facility's investigation records indicated: "'Investigation Fact Sheet: Summary and Conclusion': Incident Report Number: 18609: Allegation: Neglect failing to document skin assessment sheets by staff for consumer wound on buttocks	W0342	Direct care staff were retrained on documenting medication changes on all clients' MARs following each medication change on 12/11/12. Following any change DSPs are to fax the MAR to the nurse for review. To ensure future compliance all the MARs are reviewed by the Community services nurse on a monthly basis. Direct care staff were retrained on documenting on the skin assessments/body checks on 12/11/12. These documents are to be faxed into the nurse on a weekly basis for review and then forwarded to the service coordinator. To ensure future compliance the service coordinator will track the completion of these forms to ensure that no skin assessment/body check is missed on a weekly basis.	01/04/2013

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	area...Facts supporting the allegation: All staff stated that they stopped doing skin assessments (sic) check sheets. (sic) When notified that the wound healed by the nurse. They started back doing the assessments when notified by MEMO on 10/22/12 that they should not have stopped...Facts not supporting this allegation: [Direct Support Professional (DSP) #14] stated that she didn't receive a memo from the nurse regarding skin assessment checks...All the staff that was (sic) interviewed stated that they were under the impression that they could stop doing the skin assessment sheets, because the wound had healed, until they received a memo on 10/22/12 stated that they shouldn't have stop (sic) doing the skin assessment sheets and needed to start back...All staff was (sic) unaware of the second injury until they receive (sic) a memo on 11/8....The nurse [Licensed Practical Nurse (LPN) #1] stated that 'she told a few people that she wanted to stop the skin assessment checks, but she didn't get back to the staff to let them know that she wanted to continue the skin assessment checks.'" Further review of the investigation record indicated: "Conclusion: Parts of this allegation is (sic) true (sic) staff forgot to do skin			

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	assessment checks. The nurse [LPN #1] was unclear with her instructions to staff regarding the skin assessment checks. She didn't tell staff to continue or discontinue checking the buttock. Once the wound was healed around September 22, 2012 (sic). Therefore, staff assume (sic) that they wasn't suppose (sic) to continue skin assessment checks until the email dated 10/22/12 stated that they should have continue (sic) doing the skin assessment checks....Recommendations: Skin assessments were completed. Further however, not showing anything in the area in this investigation (sic)...." An evening observation was conducted at the group home on 12/5/12 from 5:10 P.M. until 8:10 P.M.. During the entire observation period client A utilized a wheelchair for mobility and was not encouraged and/or redirected to an alternate surface or position. A review of client A's record was conducted at the facility's administrative office on 12/6/12 at 11:22 A.M.. Review of client A's wound clinic records indicated he had a history of pressure ulcers from 3/12 to 9/20/12. Review of the 11/29/12 Wound Clinic record indicated "Wound Clinic: Non-healing wounds...left ischial wound 0.6 x 0.4 x 0.1cm...Cellerate to ischial wound every			

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	other day...return in 1 week...stage 2 pressure ulcer." The 11/29/12 Patient Visit Instructions Details sheet (physician's orders) indicated "Wound Cleansing Dressing: Remove old dressing...Cleanse the wound with normal saline prior to applying a clean dressing using gauze sponges, not tissues or cotton balls. Do not scrub or use excessive force. Pat dry using gauze sponges, not tissue or cotton balls. Protect wound and dressing and may take shower. Keep dressing dry and intact. Change dressing every other day. Cellerex applied do not wipe off. Apply new ointment each dressing change." A review of the group home Medication Administration Record (MAR) book was conducted on 12/5/12 at 6:00 P.M.. Review of the record indicated: "Health and Safety Memo" dated 11/8/12 from LPN #1 to group home staff: "[Client A] was seen at the wound clinic today for 2 wounds. One on his right foot and one above his left buttocks. He came back with the following orders: For the right foot wound: Aquacel dressing applied to wound-DO NOT REMOVE THE DRESSING- Do not get the dressing wet-Cover the dressing while bathing...For the left ischial (buttocks) wound: Cellerex applied today by wound			

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	clinic. Keep area clean and dry. Cover while bathing. New Cellerex to be applied every other day, starting Saturday, 11/10/12. Remove dressing, pat wound with a damp gauze, then pat dry with a dry gauze. DO NOT WIPE OFF THE OLD MEDICATION. Apply new layer of Cellerex and cover with a clean dressing. Keep area clean and dry. Cover while bathing. This is to be done EVERY OTHER DAY (Saturday, Monday and Wednesday) he'll return to the wound clinic on Thursday." "Health and Safety Memo" dated 11/30/12 from LPN #1 to group home staff: "[Client A] was seen at the wound clinic on yesterday for 2 wounds. One on his right foot and one above his left buttocks (sic). He came back with the following orders: For the right foot wound: This area has been resolved. For the left ischial (buttock) wound: Cellerex applied on 11/29 by wound clinic. Keep area clean and dry. Cover while bathing. New Cellerex to be applied every other day. Remove dressing, pat wound with damp gauze, and then pat dry with dry gauze. DO NOT WIPE OFF THE OLD MEDICATION. Apply new layer of Cellerex and cover with a clean dressing...." Further review of the record conducted on			

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	12/5/12 at 6:00 P.M., indicated a most current MAR dated 12/1/12 until 12/31/12. Review of the MAR indicated: "Mupirocin 2% ointment: Bactroban 2% ointment...Apply to wound topically once daily as directed." Further review indicated this medication was administered on 12/1/12, 12/3/12, 12/4/12 and 12/5/12. This medication was not administered on 12/2/12. The record failed to indicate which wound this ointment was to be applied to. Further review of the MAR did not have Cellerex, saline solution and gauze squares listed on MAR. The record indicated a most current "Health Risk Plan" for client A dated 1/17/12 which indicated: "Client is at risk for skin breakdown related to incontinence and decreased activity. Client is allergic to adhesives which can result in skin irritation. Client is a heavy wetter. Repositioned (sic) client every 4 hours and as needed. Position in another chair if possible. Check for incontinence every two hours and change as needed. Encourage client to change positions frequently. Apply treatment as ordered. Notify nurse of changes in skin condition immediately, if area becomes reddened, opens, bleeding, or irritated...." On 12/6/12 at 3:37 P.M.. SC #1			

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	submitted a 5/12 "Repositioning Risk Plan". The 5/12 risk plan indicated; "[Client A] had a history of incontinence...Due to these conditions [client A] is at risk for skin breakdown related to immobility and incontinence. Baseline: [Client A] currently spends almost all the time he is awake in his wheelchair or bed. He needs to be transferred out of his chair and/or bed to relieve pressure on his back/buttocks as well as encourage muscle movement." The 5/12 risk plan indicated: "Staff are to notify the Nurse and the Service Coordinator of any redness, openings or bleeding is observed." A review of the group home daily progress notes dated 9/1/12 to 11/30/12 was conducted on 12/6/12 at 1:15 P.M.. The 11/25/12 progress note indicated: "Ate breakfast, showered took a.m. meds. Relaxed watched t.v. after goals. After lunch, hygiene, took noon med, took a nap. He was changed for dinner, sore on butt was redressed. He clean (sic) for bed, took HS (bedtime) meds, went to sleep...Checked him every two hours changed him as needed." Further review indicated no documentation was completed on 11/1/12, 11/7/12, 11/8/12, 11/9/12, 11/10/12, 11/17/12, 11/18/12, 11/21/12, 11/22/12, 11/23/12 and 11/30/12. Review of the records			

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	indicated the group home staff failed to document any medical status in regards to client A's wound daily. A review of the facility's group home staff training records was conducted on 12/6/12 at 1:54 P.M.. Review of the 8/15/12 "Wound Care Training" did not indicate DSP #2, DSP #12 and DSP #15 had been trained in regards to wound care. Nursing Services failed to document and/or conduct any additional training in regards to wound care since 8/15/12. An interview with DSP #2 was conducted at the group home on 12/5/12 at 6:18 P.M. and 6:34 P.M.. DSP #2 indicated client A received treatments to the wound on his buttocks on Mondays, Wednesdays and Saturdays at bedtime. DSP #2 indicated if the client was wet they would change the bandage when he was toileted. When DSP #2 was asked if staff at the group home were applying the Cellerex or Mupirocin to client A's wound, DSP #2 indicated the Cellerex was being applied. When asked what the Mupirocin was being administered for, DSP #2 indicated the Mupirocin was applied to client A's wound. An interview with the group home Team Lead (TL) was conducted at the group home on 12/5/12 at 6:47 P.M.. The TL			

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	indicated Cellerex was being applied to client A's wound. When asked what Mupirocin was being applied to, the TL stated "His bottom." When asked if the Mupirocin was the same as the Cellerex, the TL stated "I'm not sure." When asked to see the Cellerex and the Mupirocin, DSP #2 and the group home TL were not able to locate the medications in the medication file cabinet until 7:15 P.M.. The Cellerex medication ointment tube was found in a clear plastic bag, which contained packaged gauze squares. The Cellerex was not labeled. The Mupirocin was found in a labeled box which indicated it was to be applied topically to wound once daily. Confidential interview C stated client A's wound "was the size of a dime." Confidential interview C stated client A's wound "is still a little open." When confidential interview C was asked how often client A's wound area was changed, confidential interview C stated "Every other day. We check when he is toileted and checked when given shower and changed." Confidential interview C also indicated they use square gauze and tape. When asked when the staff was trained in regard to wound care, confidential interview stated "I read a memo." Confidential interview C indicated she did not attend the training because she			

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	was not notified of the training held about two months ago. An interview with Service Coordinator (SC) #1 was conducted on 12/5/12 at 7:10 P.M. and 12/6/12 at 3:55 P.M.. The SC indicated the Cellerex was not on the MAR dated 12/1/12 to 12/31/12. When the SC was asked what the Mupirocin was being applied to, the SC stated "I don't know." The SC indicated the Cellerex should be listed on the MAR and the staff should document when the Cellerex is being applied. At that time the SC made a phone call. When she returned she indicated the nurse had previously told the staff to discontinue the Mupirocin and further indicated the Mupirocin should not be on the MAR. The SC indicated staff were probably applying the Cellerex but were documenting the Mupirocin instead. The SC then instructed staff to go find the box the Cellerex was in which she indicated should contain the label. The group home staff could not locate a box or a label. SC #1 indicated LPN #1 had conducted a meeting in regards to pressure ulcers and wound care at the beginning of November 2012. SC #1 further indicated there was no documentation in regards to the mentioned meeting. An interview with LPN #1 and SC #2 was			

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	conducted at the facility's administrative office on 12/6/12 at 2:26 P.M.. LPN #1 and SC #2 indicated client A had a pressure ulcer on his buttocks. LPN #1 indicated client A had a history of pressure ulcers as the client had a pressure ulcer which healed on 9/20/12. LPN #1 indicated client A's current pressure ulcer reappeared 11/8/12 as the ulcer was found at the wound clinic while being treated for a pressure ulcer to his foot. LPN #1 stated "Cellerex is to be applied to [client A's] wound every third day, Mondays, Wednesdays and Saturdays." When asked what Mupirocin was used for, LPN #1 stated "I'm not sure what that is being used for." When LPN #1 reviewed the wound clinic physicians orders dated 11/15/12 and 11/29/12, LPN #1 then indicated the Cellerex should be applied every other day, and further indicated Cellerex should be on the current MAR. When asked who documents the physicians orders and medications on the MAR, LPN #1 stated "Lead or staff." When asked who checks to make sure the MAR is documented correctly, LPN #1 stated "The fax to me (MAR) to make sure it is correct." LPN #1 indicated she had not seen client A's 12/2012 MAR. LPN #1 and SC #2 indicated the wound clinic ordered a ROHO cushion and a hospital bed for client A due to his pressure ulcers. LPN #1 and SC #2			

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	indicated client A received a ROHO cushion and bed on Monday (12/5/12). LPN #1 and SC #2 indicated the use of the adaptive equipment was not part of client A's program plan. LPN #1 stated client A's bed was "electrical" and further indicated staff were not to change the settings on the bed. When asked if staff had been trained on the use of the bed, LPN #1 stated "Not sure. I did not train them." This federal tag relates to complaint #IN00119881. 9-3-6(a)			

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W0346	483.460(d)(4) NURSING STAFF If the facility utilizes only licensed practical or vocational nurses to provide health services, it must have a formal arrangement with a registered nurse to be available for verbal or onsite consultation to the licensed practical or vocational nurse. Based on observation, interview and record review for 1 of 3 sampled clients (A), the facility failed to ensure a registered nurse was available to consult and/or oversee licensed practical nurses to ensure nursing staff met the health care needs of a client in regard to pressure ulcers. Findings include: A review of the facility's records was conducted at the facility's administrative office on 12/5/12 at 12:45 P.M.. Bureau of Developmental Disabilities Services (BDDS) report dated 11/8/12...Date of Knowledge: 11/8/12...Submitted Date: 11/9/12: "[Client A] was on scheduled medical appointment to the wound clinic for a blister on his foot. Staff at the wound clinic performed a routine body check and found a 0.7 x 0.4 x 0.1 cm pressure wound on his left ischium (buttocks)." BDDS report dated 11/8/12...Date of Knowledge: 11/12/12...Submitted date:	W0346	This tag is in error as a Registered Nurse has been on staff and available to nursing staff and regularly reviewed documentation. 1/16/13Per your request of a written employment verification regarding Marsha Clark. She was a Registered Nurse and her job title was the The Director of Health Services. Her employment was from 8/22/11 to 12/27/12. Please refer to attachment from Human Resources.	01/04/2013

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	11/16/12: "I (LPN #1) was made aware of this incident on this consumer after which I had sent him (client A) to the wound clinic on November 8, 2012. While doing a routine body check the doctor found a 0.7 x 0.4 x 0.1cm pressure wound on his left ischium (buttock). On October 22, 2012 staff was instructed to continue with doing the skin assessment sheets which staff failed to document any wound findings...." Review of the facility's investigation records indicated: "'Investigation Fact Sheet: Summary and Conclusion': Incident Report Number: 18609: Allegation: Neglect failing to document skin assessment sheets by staff for consumer wound on buttocks area...Facts supporting the allegation: All staff stated that they stopped doing skin assessments (sic) check sheets. (sic) When notified that the wound healed by the nurse. They started back doing the assessments when notified by MEMO on 10/22/12 that they should not have stopped...Facts not supporting this allegation: [Direct Support Professional (DSP) #14] stated that she didn't receive a memo from the nurse regarding skin assessment checks...All the staff that was (sic) interviewed stated that they were under the impression that they could stop			

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	doing the skin assessment sheets, because the wound had healed, until they received a memo on 10/22/12 stated that they shouldn't have stop (sic) doing the skin assessment sheets and needed to start back...All staff was (sic) unaware of the second injury until they receive (sic) a memo on 11/8....The nurse [Licensed Practical Nurse (LPN) #1] stated that 'she told a few people that she wanted to stop the skin assessment checks, but she didn't get back to the staff to let them know that she wanted to continue the skin assessment checks.'" The facility's investigation indicated "Conclusion: Parts of this allegation is (sic) true (sic) staff forgot to do skin assessment checks. The nurse [LPN #1] was unclear with her instructions to staff regarding the skin assessment checks. She didn't tell staff to continue or discontinue checking the buttock. Once the wound was healed around September 22, 2012 (sic). Therefore, staff assume (sic) that they wasn't suppose (sic) to continue skin assessment checks until the email dated 10/22/12 stated that they should have continue (sic) doing the skin assessment checks....Recommendations:...A system for ongoing wounds and other skin conditions needs to be discussed." An evening observation was conducted at the group home on 12/5/12 from 5:10			

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	15G313	A. BUILDING 00 B. WING	12/14/2012

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	P.M. until 8:10 P.M.. During the entire observation period client A utilized a wheelchair for mobility and was not encouraged and/or redirected to an alternate surface or position. A review of client A's record was conducted at the facility's administrative office on 12/6/12 at 11:22 A.M.. Review of client A's wound clinic records indicated he had a history of pressure ulcers from 3/12 to 9/20/12. Client A's nursing notes for 2012 indicated the facility's nurse (LPN) did not assess, monitor and/or develop a risk plan for client A's pressure ulcer after the pressure ulcer was discovered by a doctor at the wound care clinic. Confidential interview C stated client A's wound "was the size of a dime." Confidential interview C stated client A's wound "is still a little open." When asked how often the nurse came to the group home, confidential interview C stated "I have never seen her at this group home." When asked how does the nurse know what the area looks like, confidential interview C stated "Good question, we email her skin graph sheets that only indicate where it is. We write more information on the daily log sheets." An interview with LPN #1 was conducted			

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	at the facility's administrative office on 12/6/12 at 10:38 A.M.. LPN #1 indicated she was not aware if the facility had a policy and procedure in regard to wound care. When asked if the facility had a policy on when to contact a nurse, LPN #1 stated "I have not seen one." An interview with LPN #1 and SC #2 was conducted at the facility's administrative office on 12/6/12 at 2:26 P.M.. LPN #1 and SC #2 indicated client A had a pressure ulcer on his buttocks. LPN #1 indicated client A had a history of pressure ulcers as the client had a pressure ulcer which healed on 9/20/12. When asked how many wounds/areas client A was being treated for prior to 9/12, LPN #1 indicated client A had a wound on his buttocks. When LPN #1 reviewed the 9/9/12 "Nursing Quarterly Assessment", LPN #1 stated "Oh, he had two areas." When asked if LPN #1 had observed staff doing wound care treatment at the group home, LPN #1 indicated she observed treatments prior to 11/8/12. When asked if LPN #1 had seen client A's current wound as of 11/8/12, LPN #1 stated "No I have not, I have not been there yet." When asked how big client A's pressure ulcer was, LPN #1 stated "About the size of a quarter." LPN #1 indicated she was able to determine the size by reading client A's wound clinic notation dated			

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	11/29/12. When LPN #1 was asked how often she went to the group home to assess clients, she stated "I was going quite often, but now I have slacked." LPN #1 indicated she assessed the clients every three months at the day program. LPN #1 indicated skin assessments were to be done by group home staff twice a day. LPN #1 indicated the facility staff were to send in the skin assessment sheets daily. LPN #1 indicated the skin assessment sheets did not give any information/description of the client's wounds, they only indicated the location of the wound and/or injury. When asked who documents the physicians orders and medications on the MAR, LPN #1 stated "Lead or staff." When asked who checks to make sure the MAR is documented correctly, LPN #1 stated "The fax to me (MAR) to make sure it is correct." LPN #1 indicated she had not seen client A's 12/2012 MAR. When asked how does staff keep the dressing dry during showering, LPN #1 stated staff were "covering with saran wrap from what I was told." LPN #1 indicated there was no written protocol for client A's wound to ensure the wound stayed dry. LPN #1 and SC #2 indicated client A could reposition himself. LPN #1 and SC #2 indicated client A's program plan neglected to specifically indicate when the client should be repositioned and/or what			

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	alternate surface should be utilized. LPN #1 and SC #2 indicated the wound clinic ordered a ROHO cushion and a hospital bed for client A due to his pressure ulcers. LPN #1 and SC #2 indicated client A received a ROHO cushion and bed on Monday (12/5/12). LPN #1 and SC #2 indicated the use of the adaptive equipment was not part of client A's program plan. LPN #1 stated client A's bed was "electrical" and further indicated staff were not to change the settings on the bed. When asked if staff had been trained on the use of the bed, LPN #1 stated "Not sure. I did not train them." LPN #1 indicated facility staff did not document any specific information in regards to client A's medical/wound status. LPN #1 indicated client A did not have a current PT assessment, wheelchair assessment or nutritional assessment in regards to client A's wound care needs. When asked if client A had an updated risk plan for skin breakdown, LPN #1 stated "I don't know, I don't have access to risk plans." When asked if nursing staff were involved and had input in the development of medical risk plans for clients, LPN #1 stated "No, the SC write all risk plans for all clients." When asked if the facility had a Registered Nurse available for oversight, LPN #1 and SC #2 stated "No." When asked who was providing oversight and direct supervision			

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	over the facility's LPN staff, LPN #1 stated "[Group Home Services Director name (GHSD)]." When asked if the GHSD was a RN, LPN #1 stated "No." This federal tag relates to complaint #IN00119881. 9-3-6(a)			